EXHIBIT 6

AUTHORIZATION FOR RELEASE OF DISABILITY INSURANCE AWARD

TO: _____
Name

_____
Address

_____
City, State and Zip Code

This document will authorize you to furnish a copy of all disability insurance awards and requests for disability insurance since January 1, 2009: _____ _____ _____[Name of Insured] whose date of birth is _____ and whose last four digits of social security number are __XXX-XX-_____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records:

Name: _____
Law Firm: _____
Address: _____

This authorization does not authorize you to disclose anything other than any disability award and requests for disability insurance since January 1, 2009 to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined disability award after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____
Insured/Personal Representative Signature

Date: _____ _____
Witness Signature